ALABAMA MEDICAID OUT-OF-STATE

Enrollment Application

INSTRUCTIONS FOR COMPLETING THE APPLICATION PROCESS FOR THE ALABAMA MEDICAID OUT-OF-STATE INSTITUTIONAL

This application must be completed in black ink only.

SECTION ONE

This section pertains to the applicant. All information requested in this section must be completed.

Name: Indicates the applicant's full **business** name as listed with the State Licensure Commission.
NPI: Indicates the applications NPI number. A copy of the notification from the enumerator is required.
Physical Address: Indicates the applicant's **physical** or street address.
City, State, Zip: Indicates the City, State, and Zip Code+4 for the applicant's **physical** address.

Mailing Address: Indicates the applicant's **mailing address** or P.O. Box address.
City, State, Zip: Indicates the City, State, and Zip Code+4 for the applicant's **mailing** address.
County: Indicates the County for the applicant's **physical** location.

IRS Tax ID Number: Indicates the applicant's tax identification number. This is required for enrollment.
State License No: Indicates the License Number.
License Issue (Month / Day / Year): Indicates the date the license was issued, **not the expiration date**.
Fiscal Year End: Indicates the date of the facility's financial year end.

Provider Type: Indicates whether the applicant is a hospital or ambulance provider.
Specialty: Indicates the applicant's area of specialty (i.e. Acute care, Rehab, etc.).
Business Phone No: Indicates the area code and telephone number for the applicant's business location.
Toll Free No: Indicates the 1-800 number for the applicant's physical location.
Fax No: Indicate the area code and telephone number for the fax machine at the applicant's physical location.

Contact Person: Indicates the name of the person that should be contacted in reference to the applicant's Medicaid application and/or account.
Medicare Intermediary: Indicates the applicant's Medicare intermediary.

SECTION TWO

This information is required for enrollment as an Alabama Provider of Services.

SECTION THREE

This section pertains to the Payee (name to appear on the Remittance Advice or RA). Please complete this section if payments are to be made to a party other than the applicant. Information in this section must be consistent with the information provided to Medicare and the IRS, and will be used along with the "W9" attachment (see Addressing the Attachments) for 1099 Tax reporting purposes.

SECTION FOUR

This section pertains to Electronic Claims Submissions and Administrative Code. If you would like to receive software at no charge, please check the appropriate boxes. Please remember, Electronic Claims Submission yields a faster turnaround for claims processing. However, you are not required to submit claims electronically. If you choose to submit electronically but prefer to use a software vendor or billing agent, we will gladly forward a copy of the electronic specifications to that vendor. Electronic Claims Submission offers many options and benefits. If you need any information regarding Electronic Claims Submissions, please contact a representative at (800) 688-7989 or (334) 215-0111. If you choose to use a billing agent (a company who submits claims for you), then you must include the name of the billing agent in this section, please refer to Section 4 of the Provider Enrollment Agreement.

If you would like to receive a copy of the Alabama Medicaid Agency Administrative Code on diskette, please check the box labeled 'Yes'.

APPLICANT'S SIGNATURE

The applicant must **personally** sign and date the application.

ADDRESSING THE ATTACHMENTS

- **Alabama Medicaid Agency Direct Deposit Authorization Form -** (Electronic Funds Transfer). Please complete this form and return it with your application. This form is required for enrollment.
- **Statement of Compliance** - By completing and signing the enrollment form, you are assuring that you will operate in accordance with the "Statement of Compliance" as addressed in Section 6 of the Provider Enrollment Agreement. The "Statement of Compliance" attachment should be completed and displayed in a prominent location in your facility. Any questions concerning Civil Rights compliance should be directed to Civil Rights Coordinator, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624. **This form is required for enrollment**.
- **W-9** - This form is required. Information on this form will be used for the reporting of tax information to the IRS. Please complete the form with **INFORMATION EXACTLY AS IT IS ON RECORD WITH THE IRS**.

ADDITIONAL INFORMATION

Thank you for enrolling in the Alabama Medicaid Program. Since Alabama is similar in scope to other state Medicaid programs, but has some unique features, this information and the attached material will help you with claim submission.

- **Eligibility Verification**: It is important that recipient eligibility be verified before services are rendered since the plastic card does not contain monthly eligibility or related information. Medicaid is not liable for payment of services rendered to an ineligible recipient. Eligibility can be confirmed by calling our Provider Communications Department at (800) 688-7989 or (334) 215-0111.
- **Patients Name**: Enter the patient's last name, first name, and middle initial **as it appears on the plastic Medicaid card**. Initials should only be used when shown on the plastic Medicaid card.
- **Third Party Insurance and/or Medicare**: Always file **other insurance(s) prior to filing Medicaid**. Documentation of Third Party responses are as follows:
    1) **Third Party Insurance PAYS** - Indicate the amount of the third party payment(s) in the "amount paid" field on the claim form. A copy of the payment notice is not needed. (This is all other payments **excluding MEDICARE**)
    2) **Third Party Insurance DENIES** - Attach a copy of the denial to the claim
    3) **Medicare - Pay or Deny** - EDS supplies Medicare related claim forms at no cost. Please call (334) 215-0111 to obtain forms.

. **Prior Authorization**: If a service requires prior authorization (i.e., transplants and selected surgeries), prior approval must be obtained through the Alabama Medicaid Agency at (334) 242-5000. A written request must follow the telephone call to have the prior authorization number assigned.

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- **Filing Limit**: Providers have one (1) year from the date of service. Consult your billing manual for exceptions to this filing limit.
- **Enrollment Period**: Hospitals will be enrolled for claim date of service plus six (6) months. Ambulance providers will be enrolled for date of service only.
- **Attention Hospital Providers**: Please review your Hospital Billing Manual prior to submitting claims:
    1) Covered and non-covered revenue codes are identified in the manual.
    2) Outpatient claims require CPT-4 procedure codes. These codes are also identified in the manual.
    3) Payment for outpatient hospital services are made per CPT-4 procedure code(s).
    4) Inpatient services are reimbursed as the average per diem rate for Alabama hospitals. This rate changes each year.

If you have any questions concerning this enrollment application, please call our Provider Communications Department at (800) 688-7989 or (334) 215-0111.

ALABAMA MEDICAID OUT-OF-STATE INSTITUTIONS ENROLLMENT APPLICATION

THE FOLLOWING INFORMATION SHOULD BE COMPLETED ON APPLICANT:

Business Name (Show as Licensed) _____ NPI _____

Physical Address _____ City _____ State _____ ZIP+4 _____

Mailing Address _____ City _____ State _____ ZIP+4 _____

Tax Name _____ IRS Tax ID Number _____

State License No. _____ Lic Issue: Mo: _____ Day: _____ Yr _____ Fiscal Year End (Month) _____

Provider Type (Hospital, ASC, etc.) _____ Specialty (General Hospital, Acute Care, etc.) (1) _____ (2) _____

Business Phone _____ Toll-free Phone _____ Fax Number _____

Contact Person _____ Medicare Intermediary _____ Medicare Effective Date _____

Part 2

Reimbursement Method: (Check One) Per Diem _____ DRG _____ Percentage _____

ARE YOU CERTIFIED BY YOUR STATE TO PARTICIPATE IN THE MEDICARE PROGRAM Yes ( ) No ( )

ARE YOU CERTIFIED BY YOUR STATE TO PARTICIPATE IN THE MEDICAID PROGRAM Yes ( ) No ( )

Part 3

Please complete the following information. This information will be used on your RAs and tax statements. This information must be consistent with the payee information provided to Medicare and the IRS.

Payee Name (to appear on RAs) _____ IRS Tax No: _____

Payee Address – Street _____ City _____ State _____ ZIP+4 _____

Type of Facility: _____ Medicare Certification: _____

Business Phone _____ Toll-free Phone _____ Fax Number _____

Part 4

It is an enrollment requirement that the date-of-service for which your facility intends to bill be indicated.

DATE OF SERVICE: _____

Will you be submitting Medicaid claims electronically? Yes ( ) No ( )

(a) If you will be using a billing agent, indicate the name of the agent:: _____

(b) If you would like a free of charge copy of software for electronic billing and eligibility/benefit verification, please indicate the necessary:
CD: _____ DISKETTES: _____

(c) Do you want a Medicaid Billing manual CD? Yes ( ) No ( )

I understand there may be state and federal penalties and prosecution for the making of false statements on this application. I certify that to the best of my knowledge the information supplied on this application is accurate, complete, and is hereby released to EDS for the purpose of enrolling in the Alabama Medicaid Program.

_____ _____

Administrator's Signature (Must be personally Handwritten) **Signature Date**

If there are any questions concerning the completion of this application, please contact our Provider Enrollment at (334) 215-0111. Return this form to EDS, Provider Enrollment, P.O. Box 241685, Montgomery, AL, 36124. Please remember to retain a copy of this document in its entirety for your records. Also, please allow five (5) working days for the application to be processed by EDS.

FOR OFFICE USE ONLY, DO NOT WRITE IN THIS AREA

NPI Number _____

Effective Dates _____ to _____

Type: _____ Spec: _____

EDS ACTION

DATE: _____ BY: _____

PROVIDER ENROLLMENT AGREEMENT

WHEREAS, the Alabama Medicaid Agency, as Administrator of the Medicaid Program under Title XIX of the Social Security Act and the undersigned Provider, wish to enter into an agreement concerning submission of claims for payment, without regard to media type (paper or electronic media, including, but not limited to, magnetic tape, diskette, or on-line computers);

NOW, THEREFORE, the parties hereby agree that the provider shall submit claims consistent with the provisions of Title XIX of the Social Security Act, as amended, and under the terms and conditions set forth herein.

1. Provider hereby certifies that the services described on all claims submitted under his/her NPI number are true, accurate, and complete, that they were rendered by him/her or under his/her personal direction, and that the services were medically necessary.
2. Provider agrees to establish and maintain a file containing the signature of each recipient of services furnished by provider, or when applicable, the signature of a responsible person made on behalf of said recipient. Said signature shall be established and maintained for each claim submitted consistent with Alabama Medicaid Agency Administrative Code Rule 560-X-1-.18, as amended, herein incorporated by reference.
3. Provider hereby agrees to and shall be responsible for the accuracy and authenticity of claims submitted. Provider shall keep such records, including original source documents, as are necessary to disclose fully the nature and extent of services provided to recipients and to furnish this information, free of charge, to the Secretary of Health and Human Services, Alabama Medicaid Agency, and other State of Alabama Agencies upon request. Records shall be maintained in accordance with Administrative Code Rule 560-X-1-.21 and the Medicaid Billing Manual, as incorporated by reference, and shall be made available for inspection and audit on request. Medicaid shall have the right to recoup, adjust, or recover any incorrect payment made to provider.
4. Provider agrees that said billing agent listed in section (4) of the enrollment form is empowered and authorized to submit claims, regardless of media, on his/her behalf. Medicaid shall have the right to verify the existence of said authorization. Medicaid shall have the right to audit and confirm, for any purpose, information submitted by provider to said billing agent.
5. Provider agrees to accept as payment in full, the amount paid by Medicaid for claims submitted for payment in accordance with Administrative Code Rule 560-X-6-.01 (7). Provider also understands that submission of a claim, without regard to media type (paper or electronic media, including, but not limited to, magnetic tape, diskette, or online computers), is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, make, causes to be made, or assists in the preparation of any false statement, misrepresentation or omission of a amount, knowing the same to be false, is subject to civil and/or criminal sanctions under the applicable state and federal statures.
6. Assurance is hereby given that in accordance with Title VI (42 U.S.C., 2000d et seq.) and VII (42 U.S.C., 2000e et seq.) of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.-70b) the Age Discrimination Act of 1975 (42 U.S.C.-6101. et. Seq.), the Americans with Disabilities Act of 1990, and the regulations issued thereunder by the Department of Health and Human Services (45 C.F.R. Parts 80, 84, and 90) no individual shall, on grounds of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this facility.
7. This agreement is effective immediately upon signing and will continue indefinitely unless amended, revised, or terminated, in writing, by either party upon thirty days written notice. This agreement terminates automatically upon disenrollment of the provider from Medicaid.

PROVIDER UNDERSTANDS THAT PAYMENT OF CLAIMS SUBMITTED WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAW.

Provider's Name	Provider's Signature
NPI Number	Date Signed

THIS AGREEMENT DOES NOT OBLIGATE YOU TO ACCEPT MEDICAID PATIENTS

W-9

(Obtain TIN for payments other than interest, dividends, or Form 1099-B gross proceeds)

Taxpayer Identification Number Request

Please complete the following information. We are required by law to obtain information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 31 percent federal income tax backup withholding. Also, if you do not provide us with this information, you may be subject to a $50 penalty imposed by the Internal Revenue Service under section 6723.

Federal law on backup withholding preempts any state or local law remedies, such as any right to a mechanic's lien. If you do not furnish a valid TIN, or if you are subject to backup withholding, the payor is required to withhold 31 percent of its payment to you. Backup withholding is not a failure to pay you. It is an advance tax payment. You should report all backup withholding as a credit for taxes paid on your federal income tax return.

Instructions:

Complete Part 1 by completing the row of boxes that corresponds to your tax status. Complete Part 2 if you are exempt from Form 1099 reporting. Complete Part 3 to sign and date the form.

Part 1 Tax Status: (complete one row of boxes)

Individuals:	Individual Name:	Individual's Social Security Number (SSN): ___ ___ ___ - ___ ___ - ___ ___ ___ ___

A sole proprietorship may have a 'doing business as' trade name, but the legal name is the name of the business owner.

Sole Proprietor:	Business Owner's Name:	Business Owner's SSN or Employer ID Number: ___ ___ ___ ___ ___ ___ ___ ___ ___	Business or Trade Name

Partnership:	Name of Partnership:	Partnership's Employer ID Number: ___ ___ - ___ ___ ___ ___ ___ ___ ___	Partnership's Name on IRS records (see IRS mailing label)

A corporation may use an abbreviated name or its initials, but its legal name is the name on the articles of incorporation.

Corporation, exempt charity, or other entity:	Name of Corporation or Entity:	Employer Identification Number: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Part 2 Exemption:

If exempt from Form 1099 reporting, check here: ☐
and circle your qualifying exemption reason below

1. Corporation, except there is no exemption for medical and healthcare payments or payments for legal services.
2. Tax Exempt Charity under 501(a), or IRA
3. The United States or any of its agencies or instrumentalities
4. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions.
5. A foreign government or any of its political subdivisions.

Part 3 Signature:

Person completing this form: _____

Signature: _____

Date: _____

Phone: (_____) _____

ELECTRONIC FUNDS TRANSFER (EFT) INFORMATION

Electronic Funds Transfer (EFT) is the **required** payment method to deposit funds for claims approved for payment. These funds can be credited to either checking or savings accounts, directly into a provider's bank account, *provided* the bank selected accepts Automated Clearing House (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, **ensuring funds are directly deposited into a specified account.**

The following items are specific to EFT:

- EFT funds are typically available to providers when banks open on Thursday mornings following the checkwrite (Friday in the event of a bank holiday).
- Pre-notification to your bank takes place following the application processing.
- Ten (10) days after pre-notification, future deposits are received electronically.
- The Remittance Advice (RA) Report furnishes the details of individual payments made to the provider's account during the weekly cycle.
- The availability of RA reports is unaffected by EFT and they typically are received by the end of the week following the checkwrite.

EDS must provide the following notification according to ACH guidelines:

> "Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. The effective date for EFT under the Alabama Medicaid Program is Thursday following the checkwrite.
>
> However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATM) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn, should work out the best way to serve their customer's needs.
>
> In all cases, credits received should be posted to the customer's account date and thus be made available to cover checks or debits that are present on the effective date."

Complete the attached Electronic Funds Transfer Authorization Agreement. **A voided check or official letter from the bank must be returned with the agreement to EDS.**

ELECTRONIC FUNDS TRANSFER AUTHORIZATION AGREEMENT

Note: Complete all sections below and **attach a voided check or official letter from the bank for verification purposes.**

Type of Authorization _____New _____Change

Provider Name	Group/Payee Organizational NPI Number.
Payee Address	**Provider Phone No.**
Bank Name	**ABA/Transit No.**
Bank Phone No.	**Account No.**
Bank Address	**Type Account (check one)**

I (we) hereby authorize Alabama Medicaid Agency to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Alabama Medicaid Agency or its fiscal agent. I (we) understand that payment claims will be from federal and state funds, and that any falsification, or concealment of material fact, may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

_____ _____
Authorized Signature **(Original signature required)** Date

_____ _____
Title Internet Address (if applicable)

_____ _____
Contact Name Phone

Input By_____ Date _____

STATEMENT OF COMPLIANCE

Assurance is hereby given that in accordance with Title VI (42 U.S.C., 2000d et seq.) and VII (42 U.S.C., 2000e et seq.) of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, and the Regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84, and 90) no individual shall, on the ground of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this institution.

_____

Signature **(Original signature required)**

_____

Typed or Printed Provider's Name

_____

Date

Agency Copy *(Return with application)*

CR FORM-2

STATEMENT OF COMPLIANCE

Assurance is hereby given that in accordance with Title VI (42 U.S.C., 2000d et seq.) and VII (42 U.S.C., 2000e et seq.) of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, and the Regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84, and 90) no individual shall, on the ground of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this institution.

_____

Signature **(Original signature required)**

_____

Typed or Printed Provider's Name

_____

Date

Provider Copy *(Must be posted in facility)*

CR FORM-2